ABSTRACT

SOCIAL WORK

MOORE, ROSEMARY A.A. Borough of Manhattan Community College, 1992
B.A. City College of New York, City University of New York, 1994

A DESCRIPTIVE STUDY OF THE RELATIONSHIP BETWEEN HYSTERECTOMY AND DEPRESSION AMONG WOMEN

Advisor: Dr. Gale M. Horton

Thesis dated July, 1998

The purpose of this study was to examine the relationship between hysterectomies and depression among women between the ages of 15 and 65. Forty women were administered the Hamilton Rating Scale. The scale was used to obtain data that would measure the respondents, level of depression, to determine whether receiving a hysterectomy has any relationship to severe depression.

Findings indicated that there is a statistically significant correlation between hysterectomy and depression. Hysterectomy significantly increases the risk for depression, which often emerges as much as two years after surgery. Further studies need to be conducted in this particular area in order to follow the cases of women who undergo this procedure, and to help implement support groups to deal with the problem of post hysterectomy depression.

A DESCRIPTIVE STUDY OF THE RELATIONSHIP BETWEEN HYSTERECTOMY AND DEPRESSION AMONG WOMEN

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SOCIAL WORK

BY

ROSEMARY MOORE

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

JULY 1998

ABSTRACT

SOCIAL WORK

MOORE, ROSEMARY A.A. Borough of Manhattan Community College, 1992
B.A. City College of New York, City University of New York, 1994

A DESCRIPTIVE STUDY OF THE RELATIONSHIP BETWEEN HYSTERECTOMY AND DEPRESSION AMONG WOMEN

Advisor: Dr. Gale M. Horton

Thesis dated July, 1998

The purpose of this study was to examine the relationship between hysterectomies and depression among women between the ages of 15 and 65. Forty women were administered the Hamilton Rating Scale. The scale was used to obtain data that would measure the respondents, level of depression, to determine whether receiving a hysterectomy has any relationship to severe depression.

Findings indicated that there is a statistically significant correlation between hysterectomy and depression. Hysterectomy significantly increases the risk for depression, which often emerges as much as two years after surgery. Further studies need to be conducted in this particular area in order to follow the cases of women who undergo this procedure, and to help implement support groups to deal with the problem of post hysterectomy depression.

THESIS/DISSERTATION TRANSMITTAL FORM

Name of Student Rosemary Moore

Title of Thesis A Descriptive Study of the Relationship Between Hysterectomy And Depression Among Women

We the undersigned members of the Committee advising this thesis/dissertation have ascertained that in every respect it acceptably fulfills the final requirements for the degree of

Master Degree in Social Work
Specify degree Department of School

Major Advisor Department Date

Name Date Name Date

Name Date Name Date

As Chair of the Department of _____
I have verified that this manuscript meets the School's/Department's standards of form and content governing theses or dissertations for the degree sought.

Chair Date

As Dean of the School Social Work I have verified that this manuscript meets the School's regulations governing the content and form of theses or dissertations.

Dean Date

As Dean of Graduate Studies I have verified that the manuscript meets the University's regulations governing the content and form of theses or dissertations

Dean of Graduate Studies Date

NOTICE TO BORROWERS

All dissertations and theses deposited in the Robert W. Woodruff Library must be used only in accordance with the stipulations prescribed by the author in the preceding statement.

The author of this thesis/dissertation is:

Name: Rosemary Moore

Street Address: P.O. Box 1117

City, State and Zip: Bronx, New York 10454

The director of this thesis/dissertation is:

Professor: Dr. Gale M. Horton

Department: Social Work

School: Social Work Clark Atlanta University

Office Telephone: (404) 880-6734

Users of this thesis/dissertation not regularly enrolled as students of the Atlanta University Center are required to attest acceptance of the preceding stipulations by signing below. Libraries borrowing this thesis/dissertation for use pf patrons are required to see that each user records the information requested.

NAME OF USER	ADDRESS	DATE	TYPE OF USE

ACKNOWLEDGMENTS

I would like to acknowledge all of the special people who helped to make this work possible, especially my colleague and friend Mr. William R. Taylor for his undying support. Additionally, I would like to thank my thesis advisor, Dr. Gale Horton for his continued guidance, my practicum supervisor Mrs. Catherine Newbold Kelley, my family, especially my mother Mrs. Dorothy Jones for her support during this difficult period in my life. Thank you, mother, stepfather (Wyatt Jones), and God for making it all possible.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

Is hysterectomy really the answer for so many women? One out of three American women will be told, "You need a hysterectomy." An approximate 547,000 of them were performed in the United States in 1991.[1]

Removal of the uterus clearly saves lives for women with cancer of the cervix or uterus, but cancer accounts for only 10 percent of hysterectomies.[2] The operation can also improve the quality of life for women with chronic pain and heavy bleeding from large fibroids or severe endometriosis. But a number of health experts and consumer advocates believe 50 percent of hysterectomies and perhaps as many as 70 percent are totally unnecessary.[3]

Hysterectomy, the surgical removal of the uterus, is the second most common medical procedure performed in the United States.[4] The National Institutes of Health states that there are approximately 500,000 to 600,000 hysterectomies performed each

---

[1]Catherine Breslin, "Is This Hysterectomy Necessary?," *Women's Day Journal*, 57 (March 1994): 5.

[2]Ibid., 1.

[3]Ibid., 6.

[4]Michael D. Fetters, Gayle Fisher, and Barbara D. Reed, "Effectiveness of Vaginal Papanicolaou Smear Screening After Total Hysterectomy for Benign Disease," *Journal of the American Medical Association,* 275 (March 1996): 940.

year in the United States.[5] The increased rate of hysterectomies being performed on American women are performed for noncancerous conditions.[6] In fact, fibroid tumors are the most common reason for hysterectomies performed in the country, with about 200,000 hysterectomies per year.[7]

Malignancy can occur in fibroids, but it is extremely uncommon. But pathologists rarely study each fibroid histologically for the number of mitoses. Malignant fibroids probably account for far less than 0.29 percent. Malignant fibroids are usually selected for microscopic examination only when they appear grossly suspicious.[8]

Although hysterectomies are performed primarily for non-cancerous conditions, the increased rate of hysterectomies also appears to be affected by race and socioeconomic levels. Approximately 19.3 percent of Black women who undergo a hysterectomy are more likely to be Medicaid recipients versus the 5.7 percent of White women who belong to private health maintenance organizations. According to discharge data from the Maryland Health Services Cost Review Commission, Black women in the

---

[5]National Institutes of Health, "Conference Eyes Hysterectomy Alternatives: August 1994," (United States Health and Human Services Department 1994) , 1.

[6]Bernadine Healy, *A New Prescription for Women's Health*, (New York: Penguin Books, 1995) , 188.

[7]Ibid.

[8]Edward E. Wallach, "Myomectomy: A Guide to Indications and Techniques," *Journal of Contemporary OB/GYN*, (April 1988): 82.

state of Maryland tended to have hysterectomies at a younger age than White women.[9] The average age for Black women to have a hysterectomy is age 42. The average age for White women to have a hysterectomy is age 46.1. This represents a four year age difference between the two races of women.[10] Also, 38.7 percent of hysterectomies in Black women occur in the age group of 30 - 39 years, whereas only 27 percent of hysterectomies in White women occur in this age group.[11]

A hysterectomy occurs when the womb is removed either vaginally or through an incision in the abdomen. This procedure removes the option of bearing children forever. In contrast, an oophorectomy occurs when both the uterus and the ovaries are removed from women who are at risk for ovarian cancer.[12] About 41 percent of all hysterectomy procedures involve oophorectomies.[13] The main argument for removing the ovaries is that they may become cancerous later on. Since ovarian cancer is difficult to diagnose and treat, physicians may feel that its better to remove the ovaries.[14]

Women who decide to take their ovaries out are agreeing to what's known as a

---

[9]Ibid.

[10]Ibid., 84.

[11]L. Villarosa, *Body & Soul: The Black Women's Guide to Physical health and Emotional Well Being*, (New York: Harper Collins Publishers, 1997) , 276.

[12]Sara M. Rosenthal and Suzanne Pratt, *The Gynecological Source Book: Everything You Need to Know About the Reproductive System and How it Works*, (Los Angeles: Jack Artenstein Publishers, 1994) , 276.

[13]Ibid.

[14]Ibid., 277.

prophylactic oophorectomy, an oophorectomy performed for preventive measures.[15] In one study, 28 women with a family history of ovarian cancer were given a prophylactic oophorectomy. Three of them went on to develop cancer in the abdominal cavity that was indistinguishable from ovarian cancer.[16] Women who undergo this procedure go directly into menopause no matter how young they are. Surgical menopause is a little more drastic than natural menopause, but exhibits some of the same symptoms.[17] In addition, an oophorectomy performed before menopause raises a women's risk of developing osteoporosis and heart disease if she doesn't take hormonal replacement therapy.[18] However, there are other alternatives to this type of procedure for women who are still of the childbearing age and want to keep their uterus intact. In such cases, they are often given the option of having a myomectomy.

A myomectomy is a delicate operation to cut fibroids out of the uterus rather than simply removing the whole uterus, as in hysterectomy.[19] Myomectomy has been around for years and was often used to treat fibroids in women of childbearing age.[20] Older women are not offered a myomectomy as an option. A doctor may tell them that a myomectomy is more complicated than a hysterectomy and if they are beyond menopause

---

[15]Ibid., 279.

[16]Ibid., 281.

[17]Ibid.

[18]Ibid., 283.

[19]Wallach, 84.

[20]Ibid.

the doctor may question the logic behind it.[21] The advantage of myomectomy over hysterectomy is that woman preserves both her uterus and the possibility of having children. The disadvantage of myomectomy is that it is a longer, more painstaking operation than hysterectomy and is not entirely reliable. Roughly 20 percent to 25 percent of myomectomy patients ultimately require another surgical procedure most often, hysterectomy for recurrence of fibroids.[22] However, a hysterectomy can have a traumatic impact on a woman's life. Symptoms associated with hysterectomy are; mood swings, irritability, anxiety, poor concentration, poor memory, loss of energy, and depression.[23]

In this study, the author will look at the psychological impact of hysterectomies on women, particularly in the area of depression. Post-operative depression after a hysterectomy sets in three times more often than in other major surgical procedures. Whether women are prone to this type of depression depends on why the hysterectomy was done and the degree to which a woman believes that the surgery was a positive or negative experience in her life.[24] Traditionally, hysterectomies have been identified as causing adverse psychiatric effects on women. Apparent support has come from studies

---

[21]Ibid., 86.

[22]Ibid., 87.

[23]Ronald L. Martin, V. Robert, and Paula J. Clayton, "Psychiatric Status After Hysterectomy," *Journal of the American Medical Association* 244 (July 1980) : 351.

[24]Ibid., 352.

reporting an access of psychiatric and somatic symptoms in post-hysterectomized women.[25]

> D.H. Richards; a British physician characterizes a "post-hysterectomy syndrome", with depressed mood, hot flashes, urinary symptoms, fatigue, headaches, dizziness, and insomnia. Dennerstein a United States researcher reported a deterioration of sexual functioning in one third of those that he studied. Kaltreidal a British researcher suggests that post-hysterectomy "stress response syndrome" is a reaction to the loss of childbearing capacity.[26]

Biochemistry Perspective

The incidence of post-hysterectomy depression appears to be rooted in biochemistry. Hormonal disruptions brought on by the surgery can be far reaching, affecting the nervous system and hormonal interactions responsible for a sense of emotional well being.[27]

Recent research suggests that one particular substance, beta-endorphin, is associated with feelings of well-being. Beta-Endorphin is the natural chemicals responsible for what is referred to as a "runner's high" reported by athletes. These substances act in the body under physical stress, endorphin enables individuals to perform

---

[25]Linda Newall, *"How Hysterectomy Affects Women,"* (M.S.diss.,University of Loughborough, 1997), 2.

[26]West, 43.

[27]Health Watch, Types of Hysterectomy: Methodist Health Care System: (Women's Health Resource on-line): available from http://www.methodisthealth.com/womenshealth/hysterec.htm.); 2. Accessed 29 October 1997.

heroic feats in combat or athletic competition despite serious injuries or fatigue.[28] Their everyday role in maintaining well being is important, more modest, but vastly more important. Below normal levels of beta endorphin are associated with depression.[29]

Endorphin levels are influenced by a change in the levels of ovarian hormones estrogen and progesterone. One thought provoking study by a group of researchers at Columbia University showed that estrogen acts to stimulate the release of endorphin from the hypothalamus. This may explain why depression develops when the ovaries are removed or cease to function after a hysterectomy.[30] Another possible explanation for depression following a hysterectomy stems from the fact that when the ovaries are removed, a woman losses half of her normal supply of androgen, the hormone responsible for her sex drive.[31] Androgen contributes to feelings of well-being and to energy levels. Adding androgen to estrogen replacement for women whose ovaries have been removed can help restore libido, induce a greater sense of well-being, and boost energy levels.[32]

Despite the explanations for depression following hysterectomy. One fact still remains, the vast majority of "female problems" that lead to hysterectomy are looked upon as medically trivial. Left untreated, some can make life miserable, but it will not

---

[28]Ibid.

[29]Ibid.

[30]West, The Hystrectomy Hoax, 44.

[31]West, The Hystrectomy Hoax, 45.

[32]Ibid.

kill. But why have major surgery to remove an organ or organs that define you as a woman, and are essential to your physical, emotional, and sexual well being unless your life is in danger? No man would typically agree to have his sexual reproductive organs removed for anything short of a life threatening illness. No doctor would suggest such a radical course of action except when the alternative is certain death.[33] Medical practitioners of the past were taught that the uterus is an organ that is inherently defective, and that it is just a matter of time before it get its owner into trouble. Today's medical practioners are taught that the uterus is more than a receptacle for the fetus. Even so, to this very day, we still do not completely comprehend the role of the uterus. But this lack of understanding is not a valid reason for removing it especially if doing so can increase a woman's chance of going into severe depression.

Statement of the Problem

Depression is almost always caused by a physical illness. A hysterectomy can produce a final common pathway to the disorder of depression.[34] Each individual has a pattern of genetic, developmental, environmental, social personality, and physiological factors that combine to permit or protect against depression at any point in time. Understanding and

---

[33]Ibid., 45.

[34]John H. Greist, James W. Jefferson, *Depression and Its Treatment*, (Washington, DC.: American Psychiatric Press, Inc., 1992) , 8.

modifying the contributions of these factors is the goal of clinicians that treat depression.[35]

With the high number of hysterectomies and oophorectomies believed to be performed unnecessarily, it's very important for African American women to be more knowledgeable about the psychological impact that this surgery can have on their lives. All too often we hear sad stories about women who've gone into deep depression after surgery. There are several factors to which we can attribute the postulated relationship between hysterectomies and depression. For instance, many doctors may fail to inform their patients about the physical changes in their bodies that can have an emotional impact on their lives. Additionally, we live in a male dominated society that teaches men that it's taboo to talk to women about personal issues pertaining to their health. Some doctors may incorporate this tendency into their profession.[36] They may often fail to make the patients interest their first priority. As a result, many patients have a difficult time dealing with the traumatic experience related to hysterectomy and subsequently slip into a depressive state.[37]

The incidence of post-hysterectomy depression appears to be rooted in biochemistry. Hormonal disruptions brought on by the surgery can be far reaching, affecting the nervous system and hormonal interactions responsible for a sense of

---

[35]Ibid.

[36]West, 40.

[37]Ibid.

emotional well being.[38] Another possible explanation for depression following a hysterectomy stems from the fact that when the ovaries are removed, a woman loses half her normal supply of androgen, the hormone responsible for her sex drive.[39] Androgen contributes to feelings of well-being and to energy levels. Adding androgen to estrogen replacement for women whose ovaries have been removed can help restore libido, induce a greater sense of well-being, and boost energy levels.[40]

Significance and Purpose of the Study

In this study, the researcher hopes to determine the relationship between the physical procedure of hysterectomy and depression. Through this research, knowledge is sought to help women make the appropriate choice as to when an operation is necessary. "Women facing hysterectomy are often frightened by the experience because they lack useful information.[41] "Women of color are especially vulnerable because their access to health care is limited and a number of them may not be given alternative treatment for their gynecological disorder.[42]

---

[38]West, 43.

[39]Ibid., 44.

[40]Ibid., 45.

[41]Ibid.

[42]L.S. Wilcox, L.M. Koonin, R. Rokras, L.T. Straus, Z. Xia, "Hysteretomy in the United States," *Journal of Obstetric and Gynecology,* 83 (4), (October 1990):549-55, (Journal on-line); available from http://earth4.galib.uga.edu:4000/F...=3:next=html/Citation.html Internet; accessed 28 October 1997.

CHAPTER TWO

REVIEW OF THE LITERATURE

Historical Background

Hysterectomy, the amputation of the uterus, is on the rise. The United States has the highest hysterectomy rate in the world: two and a half times that of England and four times that of Sweden and other European countries.[1] The United States is a country in which a woman has about a 50 percent chance of having a hysterectomy before she dies.[2] The operation is one of the most frequently performed surgical procedures for women, second to cesarean sections. Thirty percent of women between the ages of thirty-five and seventy four have already had a hysterectomy.[3]

Race also appears to be a factor in the high percentages of hysterectomies performed in the United States. A University of Maryland study indicated that a disproportionate number of hysterectomies are performed on African American women,

---

[1]Dr. Clark, *Menstrual Problems, Hysterectomy & Menopause*, Clark Chiropractic Center, (Dr. Clarks Chiropractic on-line): Available from.1./.HTM; Internet; accessed 28 October 1997.

[2]Winnifred B. Cutler, Ph.D., *Hysterectomy Before & After*, (Chicago, Il: Harper Collins Publisher, 1990) , 2.

[3]Susanne Morgan, *Coping With A Hysterectomy*, (New York: The Dail Press, 1989), 60.

and they tend to have their uteruses removed at a younger age than White women.[4] The average annual hysterectomy rates in Maryland from 1986-1997 by overall age distributions and race were 49.5 per 10,000 Black women per 10,000 white women.[5] The hysterectomy rate was higher for Black women in comparison to White women at ages younger than 40, whereas it was higher for White women at age 50 and over.[6] The highest hysterectomy rates occurred in the age range of 40-49 years and were 138.2 per 10,000 Black women and 108.5 per 10,.000 White women.[7] The average age at hysterectomy was younger in Black women for nearly all diagnostic categories.

The high prevalence rate in itself makes it difficult for women to say no, or even to consider saying no. At times, it is difficult for women to feel a sense of choice about a hysterectomy; because often they will be faced with this decision at a time when physical reserves are low. Illness and fear are not conducive to free choice. Because of this, women are not in a good position to demand answers to questions or sometimes even to ask them. Some may be so anxious for relief from the symptoms, that they will happily approve any suggestion that will put an end to their problems.

During any type of illness, people can lose a certain degree of independence and control over their lives. Loss of control comes from the physical and psychological pain

---

[4]Kristen H. Kjerulff, Gay M. Guzinski, Patricia W. Langenberg, Paul D. Stolley, Nancy E. Adler Moye, and Vahe A. Kezeddjiian, "Hysterectomy and Race," *Journal of Obstetric and Gynecology,* 82 (November 1993): 759.

[5]Ibid.

[6]Ibid.

[7]Ibid., 760.

of the illness, the type of treatment needed, or the overall effects on the quality of life. Women facing or having undergone a hysterectomy may find it depressing to consider how they will be perceived by their partner sexually, or more importantly, how they will see themselves, because losing the womb to some may mean losing a vital part of femininity. Women report a feeling of loss, as they are aware that they can no longer have children or that they feel they are no longer womanly.[8] This feeling of loss may come from a lack of communication between partners. Communication between partners about major events in their lives is important as a lack of communication may precipitate marital distress.[9]

There have been reports of this occurrence as in the example of one thirty-four year old women. In one article a women states that during a physical exam, a fertility specialist told her that she had a mass of fibroids ranging in size from a "walnut to an orange."[10] The specialist went on to say that the only way she can become pregnant or carry a baby full-term would be to have a myomectomy first, a C-section-like operation that would require a six month recovery period. Her husband's response was, "have the surgery." Concerned whether the treatment was genuinely the right one and determined to avoid unnecessary or inappropriate surgery, the woman held out for a second opinion.

---

[8]Martin, Robert, Clayton, Psychiatric Status After Hysterectomy, 352.

[9]Linda A. Bernhard, and Constence R. Harris, *Partner Communication About Hysterectomy: Health Care for Women International*, (January-February 1997) , 1.

[10]Harriet A. Washington, *Fight Back Against Fibroids: Heart & Soul*, (31 March 1994) , 32.

That stress, combined with other problems, eventually led to the end of a seven-year marriage before any pregnancy could occur.[11]

Others may be frightened by dark hints that cancer is a threat, a reprehensible tactic that has been and still is used too often to scare patients into surgery.[12] Still others may be accustomed to accepting the kind of authority doctors often wield. "Many practicing physicians believe that most patients still want to be told what is best for them," states Brian Mittman, Ph.D., a RAND and VA researcher at the University of California in Los Angeles and Sepulvela VA Medical Center.[13]

With the high rate of hysterectomies occurring in society, it comes as not surprise that many are performed in response to benign female gynecological conditions, such as; uterine leiomyomas (Fibroids), menstrual difficulties, prolapsed uterus, endometriosis, chronic pelvic pain, etc.[14] Uterine leiomyomas (fibroids) account for about 30 percent of all hysterectomies. Endometriosis ranks second and leads to about 24 percent of all hysterectomies today. Prolapse, the sagging of the uterus into the vagina due to loosening of the muscular support that holds it in place, accounts for about 20 percent of all

---

[11]Ibid.

[12]Stanley West, M.D., *The Hysterectomy Hoax*, (New York: Doubleday Dell Publishing, 1994), 20.

[13]Doctor's Guide, *Women Seek Alternative To Hysterectomy For Bleeding Problems,* Medical News, (Doctor's Guide on-line): available from http://www.com/dg2/138.htm; Internet; accessed 28 October 1997.

[14]Dr. Gleen J. Bradly, *Indications for Hysterectomy*, Med Seek, Modern Alternatives to Hysterectomy (book on-line): \available from http://www/Seek.com/demo/modalt/..html;Internet;accessed 28 October 1997.

hysterectomies.[15] However the major indication for hysterectomies in African American women are more likely to be associated with fibroid tumors. Black women have a 50 to 75 percent chance of developing the tumors, compared with only one out of three for White women.[16] It is not uncommon for several women in the same family to suffer from the problem.[17]

In a recent study conducted by Blue Cross/Blue Shield of Illinois, one third of the hysterectomies performed in that state, between 1987 and 1989 were unnecessary.[18] Most of the unnecessary surgeries were performed for fibroids and other benign noncancerous conditions.[19] A primary factor that contributes to hysterectomies is fibroids. Fibroids are benign: meaning noncancerous; tumors that grow inside the uterus. Fibroids develop most commonly in women who are in their 30's and 40's, but can also develop earlier or later. In fact, about 30 percent of all women will develop fibroids by the time they reach 35 years of age.[20] Black women have a 75 percent chance of developing fibroids by the time they reach 35 years old.[21]

---

[15]West, 125.

[16]Teresa Wiltz, "Hysterectomy Hysteria," *Essence*, (October 1992): 24.

[17]Paula Dranov, "When the Diagnosis is Fibroids," *Journal of American Health*, (September 1993): 70.

[18]National Institutes of Health, "Conference Eyes Hysterectomy Alternatives: August 1994," (United States Health and Human Services Department 1994): 3.

[19]Ibid.

[20]Dranov, When the Diagnosis is Fibroids, 70.

[21]Rachel Jackson Christmas, "Fibroids A Report," *Essence*, (January 1994): 60.

Many Black women suffer serious complications from fibroids in comparison to White women. The primary reason given for this phenomenon is that Black women have inadequate health insurance. Black women are more likely to be Medicaid recipients (19.3 percent of Black women versus 5.7 percent of White women) or belong to a health maintenance organizations (16.8 percent versus 8.8 percent), and less likely to be insured by Medicare (5.1 percent versus 11.5 percent) or have private insurance (57.2 percent versus 72.7 percent).[22] As a result they may fail to get routine medical checkups early or often enough. "Far too many black women delay getting basic gynecological exams," states Ezra C. Davidson, Jr., M.D., president of the American College of Obstetricians and Gynecologists.[23] By the time they get into a doctor's office, their presentation of fibroid tumors is often dramatic.[24]

Some health care professionals and scientists attribute fibroids to the presence of internal imbalance, emotional problems, and a diet that is not right for Black women.[25] According to Daya Associates in Harlem, New York, "About 70 percent of my female clients have fibroids, which I believe are an accumulation from high cholesterol diets. Black women need to spend their money on juicers and organic vegetables."[26] Failure to eat healthy foods can pose major disadvantages to a woman's health.

---

[22]Ibid., 71.

[23]Ibid.

[24]Ibid.

[25]Evelyn C. White, "More on Fibroids," *Essence*, (December 1991): 26.

[26]Ibid.

According to Dr. Stanley West, Chief of Reproductive Endocrinology and Infertility at St. Vincent's Hospital and Medical Center in New York City, states "Hysterectomy is permanent." Once your uterus is gone, it's too late to change your mind about having children or restore the uterus if you find you're having unacceptable symptoms." Forty percent of hysterectomy patients who have their ovaries removed along with the uterus are plunged into premature menopause.[27] Their bodies suddenly stop producing estrogen, which leads to a series of menopausal symptoms.[28] A lack of estrogen also puts them at a higher risk for osteoporosis, heart disease, perhaps even Alzheimer's disease.[29]

In addition to those issues, women who have had their ovaries removed may be frightened of all the menopausal symptoms that may await them. The symptoms may be severe, such as hot flashes, night sweats, decreased libido, sweating, heart palpitations known as vasomotor symptoms, and changes in the vagina, which can include changes in the acidity levels and dryness due to reduction in secretions from the mucous glands.[30] All of these symptoms can lead to pain during sex and increase the risk of bleeding and infection. The bladder and urethra lining become thin and weak and stress incontinence

---

[27]Stanley West, M.D., *The Hysterectomy Hoax*, (New York: Doubleday Dell Publishing, 1994) , 38.

[28]Ibid., 45.

[29]Ibid.

[30]Healy, 201.

can occur as muscles atrophy.[31] Women may also experience breast changes as a result of the reduction in the production of estrogen.[32] The breasts may become smaller and less elastic and the skin may become thinner and dryer. Skin and hair often become dryer and the elasticity of the skin reduces which increases the appearance of wrinkles. The change in the skin are due to damaging effects on the connective tissues and collagen, when the estrogen production decreases.[33]

The ovaries manufacture hormones that regulate the menstrual cycle as well as pregnancy, protect a woman against heart attack, stroke, and bone loss, keep her skin looking young, prevent atrophy of her vaginal tissues, and make it easier for her to lose weight than for a postmenopausal woman.[34] After oophorectomy, removal of the ovaries, women may want to start hormone replacement therapy to prevent fibroids from developing.

There are numerous benefits that come with hormone replacement therapy; for many women the benefits clearly outweigh the risks. For example, many of the major

---

[31]Ibid.

[32]Harriet, 202.

[33]Ibid.

[34]Ibid.

risks that women face are diseases related to heart failure, stroke, osteoporosis, and Alzheimer's disease are reduced by hormone replacement therapy, and often even the mood improves with the right prescription.[35] The risk of endometriosis and breast cancer is controllable by tailoring the dose and preparation and consistent follow-up screening by a doctor.[36]

Holistic Practice

According to Paula Dranov, a New York City based writer specializing in women's health issues, "fibroids run in families. For example, if a mother has fibroids, her daughter is likely to develop them as well."[37] Although there are many speculations about the symptoms and causes of fibroids, many holistic practitioners believe weight and dairy products are contributing factors.

Dr. Ronald Davidson, a holistic general practitioner in New York City, states, "being overweight is a problem affecting 49 percent of African American women." He went on to say that tumors are more common among African American women because they have moved further away from their traditional diet and lifestyle that any other cultural group. To heal and prevent fibroids, Davidson recommended getting back to nature. "Eat more like a West African, a Native American, a Brazilian, or a Jamaican.

---

[35]Ibid., 45.

[36]Ibid., 47.

[37]Ibid.

To be specific, stop eating or drastically cut down on the amount of meats and dairy products and consume more whole grains, beans, vegetables and fruit."[38]

Many holistic practitioners suspect that dairy products are linked to fibroid tumors.[39] A nutritional consultant based in Harlem, New York, believes the growth hormones given to cows wreak havoc on the human reproductive system.[40] She also states that once her clients abandon dairy products, many of their tumors and associated reproductive problems dissolved."[41]

Although there are many speculations about the causes of fibroids, perhaps one fact still remains: fibroids are responsible for the increased rate of hysterectomies in Black women. The National Hospital discharge Survey stated that approximately 1.7 million women had a hysterectomy during 1988-1990.[42] The highest rates of 100.5 hysterectomies per 10,000 women were for women aged 30-54 years. Total rates of hysterectomy for Black women were similar to those for White women. According to the Journal of Obstetric and Gynecology by L.S. Wilcox, Seven percent and 56.5 percent per 10,000 black women underwent a hysterectomy, respectively. Uterine leiomyoma

---

[38]Rachel H. Jackson Christmas, "Fibroids a Report," *Essence,* (January 1994): 60-62.

[39]Kimberly Knight, "Health Dairy Tales," *Essence*, (May 1993): 32.

[40]Ibid.

[41]Ibid.

[42]L.S. Wilcox, L.M. Koonin, R. Pokras, L.T. Straus, Z. Xia, "Hysteretomy in the United States," *Journal of Obstetric and Gynecology,* 83 (4), (October 1990): 549-55, (Journal on-line); available from http://earth4.galib.uga.edu:4000/F...=3:next=html/ Citation.html Internet; accessed 28 October 1997.

fibroid tumor" was reported as the primary diagnosis for 61 percent of Black women and 29 percent of White women.[43]

Surgical or Unnecessary Hysterectomy Procedures

For decades it was estimated that more than 600,000 women in the United States would undergo a hysterectomy.[44] Lack of understanding of the cellular biology of virus activity in the cervix created an exaggerated fear of cancer leading to hysterectomy being performed on tens of thousands of women who would otherwise today have the condition being treated in an office setting. In spite of the increased information concerning the frequency of hysterectomies performed in society, a disproportionate number of them are being performed on minority women.[45]

One study with over 12,000 post-hysterectomized women from fifteen states, confirmed that poor and poorly educated women were more likely than their counterparts to have a hysterectomy.[46] Many women of minority groups are poor, and the health care they receive is often in public hospitals or teaching hospitals.[47] Doctors in teaching

---

[43]Ibid.

[44]National Institute of Health, *Conference Eyes Hysterectomy Alternatives,* Health and Human Services Department, (Government Reporter, 1994), 1.

[45]Kristen H. Kjeulff, Ph.D., Gay M. Guzinski, MD., Patricia W. Langenberg, Ph.D., Paul D. Stolley, MD., MHP, Nancy e. Adler Moye, MA, Vahe A. Kazarddjiian, Ph.D., "Hysterectomy and Race," *Journal of Obstetrics and Gynecology*, 82 (November 1993): 759.

[46]Ibid.

[47]Susanne Morgan, *Coping With a Hysterectomy*, (New York: The Dail Press, 1980) , 70.

hospitals are under pressure to perform a certain number of hysterectomies for their teaching experience.[48] Frequently minority group women are victims of doctor's pressuring them into surgical procedures they may not want.[49]

"The uterus is a favored target for unscrupulous doctors who deliberately use scare tactics to persuade patients to have high priced, unneeded surgery," states Herbert Keyser M.D. author of *Women Under the Knife*.[50] Women before surgery need to get a second opinion. Second, they need to learn as much as they can about the various alternative treatment, and their advantages and disadvantages. A well informed woman who understands her own body and how it works has an enormous advantage when she develops a gynecologic disorder.

Insurance companies also often have a financial interest in encouraging hysterectomies. As long as a woman has her uterus, she can develop problems that her insurance must cover. Preserving her uterus continues that potential liability.[51] The American way of encouraging hysterectomy operation tells us a lot more about doctors and insurance companies than it does about disease.[52]

---

[48]Ibid.

[49]Ibid., 71.

[50]Catherine Breslin, "Is This Hysterectomy," *Women Day Journal*, 57 (15 March 1994): 2-5. (Journal on-line); available from; edu:400/FETCH...=F:reno=9:next+html/citation.html;Internet; accessed 27 October 1997.

[51]West, 13.

[52]Ibid.

Medicine is a system of social control.[53] It reflects the American social system.[54] The people with the most authority, mainly doctors, tend to be White, wealthy, and male.[55] Women's role in the medical system reflects women's role with larger society. Women are looked upon as nurtureres, or nurses, and are seldom in decision making positions. Minority group members, in particular children, the elderly, the disabled, and the poor have especially powerless positions in the health system.[56] The reason for this, in general, are policies applied to low-income minority women.

The Reagan administration in 1981 proposed massive cuts in public health spending. The policy responsible for the funding of abortion and sterilization shows a disturbing relationship. Federal, state, local funding for abortion has been cut off in most areas. Yet the federal government still assumes 90 percent of the cost of sterilization operations under Medicaid.[57] A confirmed 35.3 percent of all women of childbearing age in Puerto Rico, and perhaps as many as 25 percent of all Native American women, have been sterilized, many of them involuntarily.[58] Sterilization of minority women is more common in certain geographical areas. A study conducted in New York City found that

---

[53]Morgan, 70.

[54]Ibid., 69.

[55]Ibid., 72.

[56]Ibid., 74.

[57]Ibid., 76.

[58]Ibid., 77.

twice as many Blacks and six times as many Hispanic women in comparison to White women were sterilized in municipal hospitals.[59]

In the south, nearly 250,000 women per year undergo hysterectomy. In contrast, about 82,000 women living in the Northern United States, the region of the country with the lowest incidence of hysterectomy, undergo the procedure.[60] The South generally has the highest overall rate of hysterectomy and the rate of surgery for younger women is higher in the South than elsewhere in the country.[61]

Although hysterectomy is the second most common major non-obstetric operation performed in the United States, many authorities believe that hysterectomy is often unnecessary and unjustified. More than 90 percent of hysterectomies are often unnecessary.[62] Consequently, the surgery can have long lasting physical, emotional, and sexual consequences that may undermine women's health and well being.[63] It is no secret that many women develop serious health problems after a hysterectomy including; depression, fatigue, urinary disorders, joint aches and pains, and unwelcome changes in sexual desire.[64]

---

[59]Ibid. 77.

[60]Ibid., 78.

[61]Ibid.

[62]Ibid.

[63]Ibid., 83.

[64]Ibid.

Impact of Hysterectomies

A study conducted on 33 percent of mature women who entered menopause early from surgery versus 12 percent of women who entered menopause had heart attacks.[65] A hysterectomy can have a traumatic experience on a woman's life. The after effects of hysterectomy are most dramatic when the estrogen producing ovaries are removed from premenopausal women. Unless a woman begins estrogen replacement therapy soon after surgery, she will almost certainly begin to experience hot flashes. Other symptoms can include fatigue, insomnia, urinary problems, headaches, dizziness, vertigo, nervousness, irritability, anxiety, weight gain, vaginal dryness, diminished physical strength, difficult or painful sexual intercourse, hair loss, and a variety of skin problems.[66]

Despite the fact that so many women encounter so many problems, very few scientific studies are conducted in this particular area. D.H. Richards, a British researcher found that hysterectomy was much more likely to lead to post-operative psychological problems, depression in particular.[67]

The incidence of post- hysterectomy depression appears relatively widespread. In the past, the problem usually was attributed to the women's neurotic belief that hysterectomy robbed her of her femininity or if she was childless, to the fact that it blighted her hopes for children. As of this date there is much information about the mourning process women undergo following hysterectomy. Surveys conducted have

---

[65]West, 12.

[66]Ibid.

[67]Ibid., 15.

come to the conclusion that post- hysterectomy depression is more likely to occur if the woman's personal or family history indicates depression as a strong risk factor. (It can also include her belief that sex will be less welcome or pleasurable or that her husband or lover will react negatively).

Alternatives to Hysterectomies

Though there is widespread publicity surrounding the increased rate of hysterectomy performed in North America, the cost itself can be too high physically, emotionally, sexually and economically for a woman to stand idly by when there can be other options to having her uterus removed. One such procedure is called laparoscopically assisted vaginal hysterectomy. Thin tubes are inserted through tiny incisions in the abdomen near the navel. The uterus is then removed in sections through the scoping tube or through the vagina.[68] Although the method can take longer to perform, there is usually a shortened period of recovery in the hospital.

The procedure can be very expensive. Thirty-four researchers at the Greater Baltimore Medical Center examined 1,049 cases during 1993 and 1994. They found that the new procedure cost $6,116 per procedure on average, compared with $5,084 for an abdominal hysterectomy and $4,2212 for a traditional vaginal hysterectomy. Overall, costs were higher for the laparoscopic method, even tough it resulted in shorter hospital

---

[68]Health Watch, Methodist health Care System: "Types of Hysterectomy," (Women's Health Resource on-line): available from http://www.methodisthealth.com/WomensHealth/Hysterec.html.), 2. Accessed 29 October 1997.

stays: 2.6 days compared with 3.9 days of an abdominal hysterectomy and 2.9 days for a vaginal hysterectomy.[69]

Another procedure called uterine a balloon therapy system is a new technique, developed by Gynecare Inc., of Menlo Park, California. The new procedure is being tested by gynecologists at some of the nation's top hospitals. One in particular is Dr. Robert Newirth, Director Emeritus at St. Luke's Roosevelt Hospital Center in New York City. Dr. Newirth advises the procedure for treating menorrhegia. The Uterine Balloon Therapy System consists of two concepts: a balloon catheter containing healing and sensing elements, and a controller unit. The catheter is inserted through the cervix into the patient's uterus. A syringe is used to pump a sterile solution through the catheter into the balloon, which is inflated to the dimensions of the uterus. A heating element in the catheter heats the fluid to nearly 190 degrees F, destroying the endometrial lining and the device is withdrawn when this occurs.[70] The women's option of bearing children is taken away forever. The procedure destroys the endometrial lining, which must be intact to bring a pregnancy to term.

The balloon technique is far simpler than a hysterectomy. Hysterectomies, by contrast, usually require general anesthesia, several days of hospitalization and four to six weeks recuperation. Hysterectomy is also accompanied by risk of complications,

---

[69]Winnifred B. Cutler, Ph.D., *Hysterectomy Before & After*, (Chicago, IL: Harper Collings Publishers, 1990) , 7.

[70]USA, Science, *Study Launched on Hysterectomy Alternative,* (Women Health on-line); available from today.com/life/health/women/hyster/whyoo1./1.htm;Internet;accessed 4 September 1997.

including infections and damage to the bladder and bowel. Whereas balloon therapy can be done in an office, with local anesthesia and will only last approximately 8-12 minutes. "The patient can leave the office within an hour and be back to work the following day," states Dr. Robert London of Kaiser Permanente, the nation's largest health maintenance organization.[71]

Surgical Negligence

It is time for women to fight back, and to recognize hysterectomy for the threat it really can be to their overall health, and to refuse to have the surgery except when their lives are at stake. Such an incident occurred when a 34-year-old army wife successfully sued the federal government's Walter Reed Army Medical Hospital, in Washington DC, for advising her that it was medically necessary for her to undergo a hysterectomy when, in fact, it was not. He also failed to inform her of the negative side effects she would endure after surgery. Consequently, her side effects included depression, sleeplessness, loss of appetite and weight, severe headaches and lack of libido.[72]

Another incident occurred with Nora Coffey, of Bala Cynwyd, Pennsylvania. In her case, she was told at 36 that she probably had ovarian cancer. It turned out that all she had was a large benign cyst. After suffering severe adverse reactions to her hysterectomy, including profound fatigue, loss of stamina and a demolished sex life,

---

[71]Ibid., 8.

[72]Dr. Weil, Uterine Fibroids, Natural Health & Natural Medicine: (Dr. Weil's Database on-line) available from http://egi.Pathfinder.comaawhxxpkgUABs...i1/database/display/o,14112,113,00.htm1;accessed 28 October 1997 , 2.

Coffey launched the HERS Foundation (Hysterectomy Educational Resources and Services), to provide other women with the medical data she couldn't find herself at the time of her surgery.[73] Women must be taught to value their reproductive and sexual organs as much as a men value theirs. Imagine the outcry if 300,000 men were castrated every year in America just in case their testicles became diseased. When a man has confirmed testicular cancer, doctors go to great lengths to try to save one testicle. In women, the cancer need not even be present for the ovaries to be removed.

If a woman is told she needs a hysterectomy, she should pursue a second opinion. Cornell University Medical Center, a leading hospital in New York City, found that second opinions in hysterectomies cases did not confirm the original doctors recommendations in nearly half of all cases.[74] Many doctors are not providing their patients with important information about the possible side effects of hysterectomy and the many alternative treatments. The gynecology field is still male dominated and there is no question there is a paternalistic attitude out there states Dr. Donald Goldstein, a clinical professor of Obstetrics and Gynecology at Harvard Medical School.[75] However, as more women physicians and younger male doctors who are "attuned to the women's movement" enter the field, "informed consent" will really mean what it says.

---

[73]Dr. Clark, *Menstrual Problems, Hysterectomy & Menopause*: Clark Chiropractic Center. (Dr. Clark's Chiropractic on-line); available from http://www.flash.net-clarkjm/menstrual./2-4htm; Internet; accessed 28 October 1997 , 2.

[74]National Women Health Report, "Women's Health Resource Center: Alternative to Hysterectomy," (Women's Health Resource Center on-line) available from http:www.Womenshealth.com/rch2.html;Internet;accessed October 1997 , 1.

[75]Ibid., 2.

Depression & Hysterectomies

There are many side effects that come with having a hysterectomy. These side effects may manifest themselves emotionally, physically, or psychologically. Depression is one of the most common side effects. Women may experience mild, moderate, or severe depression. Those women who experience depression may overcome it by themselves or they may require professional help.

There are many factors that may contribute to the degree of depression that a woman may experience after having a hysterectomy. A woman may experience a profound sense of loss and begin to grieve over the removal of her female organs. She may also begin to question herself and her femininity. She may begin to feel that she is not a complete woman due to the lost of her child bearing organs. She may also struggle with her family's perception of her after the operation. Women often feel that their family members (especially their spouses), tend to view them differently after a surgery of this type.

Research suggests that the depression may be due to some physiological aspects of the body. Hysterectomies may cause some hormonal change that could trigger depression is some women.[76] Many surgeons vary in their thinking on post surgical depression among women who have experienced a hysterectomy. One of the reasons for this is that in most cases depression doesn't tend to occur immediately after the operation.

---

[76]Morgan, 115.

In some cases the surgeon will have completed the normal post surgical checkups before the onset of depression occurs.[77]

Surgeons need to become more sensitive to the issue of post- hysterectomy depression. They need to acknowledge the fact that this phenomenon frequently occurs in women who choose to undergo this particular procedure. Women need to be aware that there is a chance that they may experience some degree of depression after having a hysterectomy. By working together more closely, the surgeon and the patient may be able to come up with strategies for coping with this phenomenon that may significantly reduce the intensity and the duration of post- hysterectomy depression.

Theoretical Framework

The theoretical framework used for this study will be Cognitive Behavioral Theory. This approach is based on the assumption that cognition, emotion, and behavior interact significantly and have a reciprocal cause and effect relationship.[78] This theory emphasizes the importance of social functioning by assisting the client to learn more realistic and positive ways of perceiving, thinking, and interpreting life experiences. According to this perspective people contribute to their own psychological problems, as well as specific symptoms, by the way they interpret events and situations in their life.[79]

---

[77]Ibid.

[78]Gerald Corey, *Theory and Practice of Counseling and Psychotherapy, 5th ed.* (California: Brooks & cole Publishing Company, 1996) , 319.

[79]Ibid.

The cognitive behavioral approach is basically a structured psycho-educational model, that emphasizes the role of homework, places responsibility on the client to assume an active role both during and outside of therapy sessions and draws from a variety of cognitive and behavioral strategies to bring about change.[80] One in particular is rational emotive behavior therapy.

Rational emotive behavior therapy departs radically from other approaches. Namely, the psychoanalytic, person-centered, and Gestalt approaches. REBT has more in common with therapies that are oriented toward cognition and behavior in that it stresses thinking, judging, deciding, analyzing, and doing. It has been characterized as being highly rational, persuasive, interpretative, directive, and philosophical.[81] Another is Aaron T. Beck's cognitive therapy and Donald Meichenbaum's cognitive behavior modification.

Although there are methodological differences amongst all three approaches, they share the following attributes: (1) a collaborative relationship between the client and therapist, (2) the premise that psychological distress is largely a function of disturbances in cognitive processes, (3) a focus on changing cognition's in order to produce desired changes in affect and behavior, and (4) a generally time limited and educational treatment focusing on specific and structured target problems.[82]

---

[80]Ibid., 320.

[81]Ibid.

[82]Ibid., 321.

This framework is relevant for this study. Using this theory, it is believed that an event such as, a hysterectomy can have a significant impact on women's level of depression. Women facing or having gone through with a hysterectomy may find it depressing to consider how she will be perceived by her partner sexually, or more importantly how she will see herself, because losing her womb may mean losing a vital part of femininity. This theory plays an important role in my study, by encouraging the client to work on her thinking and acting rather than primarily with expressing feelings. The therapy teaches the client straight thinking. It attempts to help clients reduce their faulty thinking by questions, logic, advice, information, and interpretations.

Statement of the Hypothesis

The research hypothesis asks: does a hysterectomy increase the level of depression in women? The null hypothesis states that there is no statical relationship between hysterectomies and the level of depression women experience. Variables are discussed in the method.

Terms and Definitions

Depression - "Dejection feelings of sadness, melancholy, despair, hopelessness, pessimism, despondency, gloominess, discouragement."[83]

---

[83] *Websters New Reference Dictionary of the English Language*, (Nashville: Thomas Nelson Publishers, 1984) , 78.

Estrogen - Any of the female sex hormones, produced by the ovaries or prepared synthetically.[84]

Fibroid - Resembling or constituting fibrous tissue. A benign tumor occurring in the uterine wall.[85]

Hysterectomy - Surgical removal of the uterus.[86]

Hysteria - Psychoneurotic disorder marked by extreme excitability and disturbances of various psychic and physical functions.[87]

Menopause - The period usually occurring between the ages of 45 and 40, during which menstruation ceases.[88]

Myomectomy - The surgical excising of a uterine fibromyoma or leiomyoma.[89]

Oophorectomy- The surgical removal of one or both ovaries.[90]

---

[84]Ibid., 435.

[85]Ibid., 437.

[86]Ibid., 445.

[87]Ibid.

[88]Ibid., 456.

[89]Ibid., 458.

[90]Ibid., 710.

CHAPTER THREE

METHODOLOGY

Design and Sample

The mode of observation that will be used to collect the data will be survey research. The sample from which this study will be drawn will be forty women who have undergone a hysterectomy for a gynecological disorder. All participants of the study are residents of the metropolitan Atlanta area. Data was collected by administering a questionnaire at an urban public health center. The questionnaire was administered by myself and a physicians assistant. The method of sampling will be purposive/judgmental (non-probability) sampling. This method was chosen because all participants have underdone a hysterectomy, and may share similar experiences of post- hysterectomy depression.

Instrument

One questionnaire that will be used in this study was created in June 1960 by M. Hamilton in Glendale, California.[1] It is divided into three sections: demographic information consisting of five questions, general health consisting of seven questions, and clinical depression consisting of eighteen questions from the Hamilton Rating Scale which is designed to assess the symptoms of patients diagnosed with depression.[2] The Hamilton Rating Scale contains twenty one variables evaluating the severity of depressive symptoms which are based on the 18 selected items that were used for this study. The

---

[1]Hamilton, M. Hamilton Rating Scale for Depression (HRSD). (Glendale, California: Cinahl Information Systems, 1960.

[2]Halmilton, M. "Development of a Rating Scale for Primary Depressive Illness," *British Journal of Social and Clinical Psychology*, 6 (1967): 278-296.

variables being tested in the depression section are behavioral changes in mood that some women experience as a result of undergoing a hysterectomy.

Data Analysis

The information obtained from the questionnaire will be entered into a computer program, Statistical Package for the Social Sciences (SPSSWIN). The data will be analyzed using descriptive statistics: mean, median, and mode. The non-probability test of Chi-Square will be used to determine if there is in fact a significant relationship between the variables: hysterectomy and depression.

CHAPTER FOUR

PRESENTATION OF RESULTS

Data for the following statistical analysis were collected from a sample of forty participants. Descriptive statistics was used to evaluate the data results. In table 1... Frequency Distribution of Demographics shown below you will find the different areas of demographics surveyed in this study and the frequency of their distribution.

Table 1: Frequency Distribution of Demographics

(N=40)

VARIABLE	FREQUENCY	PERCENT
Race		
White	8	20
Black	22	55
Hispanic	8	20
Native American	0	0
Asian American	0	0
Other	2	5
Current Marital Status		
Married	8	20
Single	2	5
Divorced	14	35
Separated	10	25
Cohabitating	5	12.5
Educational Level		
High School	10	25
College	22	55
Graduate School	6	15
Other	2	5

In Table 1 above the demographic make up of this group regarding ethnicity was as follows: 20 percent were White, 55 percent were Black, 20 percent were Hispanic, 5 percent were others. The ages of the participants were: 5 percent 24-25 years old, 50 percent 35-44 years old, 45 percent 45-54 years old. Current marital status of participants

shows that: 20 percent were married, 5 percent were single, 35 percent were divorced, 25 percent were widowed and, 12.5 percent were cohabitating. Educational status of this sample reflected that 25 percent completed high school, 55 percent had a bachelors degree, 15 percent have graduate degrees and, 5 percent reported other. As far as household income, 40 percent reported income below $10,000, 50 percent ranged $10,000 - $20,000, 5 percent ranged $30,000 - $50,000 and, 5 percent reported $50,000 and over.

Table 2 below shows the frequency of distribution of health conditions grouped by; the age group of hysterectomy symptoms, gynecological disorder prior to hysterectomy, family history of hysterectomy, choice of treatment, and the total satisfaction of hysterectomy patients with the present physical conditions. The findings are listed in table 2.

Table 2: Frequency Distribution of Health Condition

(N=40)

VARIABLE	FREQUENCY	PERCENT
Age Group of Hysterectomy Symptoms		
15-24	2	5
25-34	6	15
35-44	14	35
45-54	18	45
55-64	0	0
64 or more	0	0
Gynecological Disorder Prior to Hysterectomy		
Fibroid Tumor	14	35
Cervical Cancer	2	5
Endomentriosis	4	10
Abnormal Bleeding	12	30
Chronic Menstrual Pain	5	12.5
Prolasp Uterus	2	5
Other	1	2.5
Family History of Hysterectomy		
Yes	36	15
No	4	85
Choice of Treatment		
Myomectomy	6	15
Hysterectomy	20	50
Prescription Drugs	8	20
Other	6	15
Satisfaction With Physical Condition		
Yes	26	65.5
No	14	34.5

Table 2 above shows the number of women who have experienced gynecological problems between the ages of 15-24 years is 5 percent, 25-34 15 percent, 34-44, 35 percent, 45-54, 45 percent and, 55-64 0, 65 or more reported 0. The average age of the participants at the time of their hysterectomy was 40 percent 34-44 years old, 40 percent 45-54 years old, 15 percent 25-34 years old, 5 percent 15-24 years old.

All of the participants were diagnosed with some form of gynecological disorder prior to their hysterectomy. Thirty-five percent were diagnosed with fibroid tumors, 5% with cervical cancer, 5% with prolasp uterus, 10% with endometriosis, 30% with abnormal bleeding, 12.5% with chronic menstrual pain, and 2.5% for some other form of gynecological disorder. Ninety percent of the women who participated in this study had a family history of hysterectomy, 15% of the women who participated in this study were offered an alternative treatment plan - Myomectomy were offered to 1.5% of those who were given alternative treatment plans, 15% were other treatment plans. Seventy five percent of the women who participated in the study had regrets about having surgery, 25% had no regrets, 34.5% were satisfied with their physical condition after surgery, whereas 65.5% were not satisfied.

Fifty-five percent of the women were in a depressed mood, 70% had feelings of guilt, 6.5% had insomnia, 52.5% were agitated, 67.5% had feelings of anxiety, 55% had loss of sexual interest, 62.5% lost a significant amount of weight, 60 were easily frustrated, 67.5% had an impaired ability to concentrate, 52.5% had decreased motor activity, 55% lost interest in extra curricular activities. In Table 3, Chi-Square Analysis of Depression and Hysterectomy you will find that there is a statistically significant relationship between hysterectomy and depression. The findings are shown in table 3.

Table 3: Chi-Square Analysis of Depression and Hysterectomy

(N=40)

Dependent Variable	DF	Chi-Square Value
1. Do your find yourself in a depressed mood sometimes?	21	32.67
2. Do you have feelings of guilt about having a hysterectomy?	27	45.16*
3. Do you have thoughts about suicide?	7	19.12*
4. Do you have insomnia during the early morning hours?	25	42.70*
5. Do you work or have extracurricular activities?	16 15	26.30 25.00
6. Do you become agitated sometimes? (Do things to yourself to bring about attention)	20	31.41
7. Do you have feelings of anxiety?	20	36.46*
8. Do you have a lost of sexual interest?	21	37.72*
9. Did you have any menstrual disturbances prior to your surgery?	21	37.72*
12. Do you have any paranoid symptoms? (Having delusions)	23	40.22
13. Do you have obsessive compulsive symptoms?	20 19	40.22* 31.41
14. Do you have a slowness of thought or speech?	20	36.46*
15. Do you have an impaired ability to concentrate?	22	38.97*
16. Do you have decreased motor activity?	20	31.41
17. Do you have a lost of interest in activities, hobbies?	21	32.67
18. Did you seek medical advice or counseling for your condition?	18	28.87

(P=.05)

The above table shows that there is a statistically significant relationship between hysterectomy and depression.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

The hypothesis stated that a hysterectomy increases the level of depression in women. The analysis of the relationship between hysterectomy and depression revealed that there is a statistically significant correlation between hysterectomy and depression. Therefore, the null hypothesis is rejected.

The null was rejected, because the study proved that a hysterectomy demonstrated a relationship to severe depression. In one study, investigators concluded that 70% of hysterectomized patients suffered a severe depression within three years of their surgery which is more than double the rate of age-matched controls who became depressed in the same span of time.[1] Unfortunately, many well-meaning physicians are not aware of the true and documented relationship between hysterectomy and depression. Many physicians who perform this surgery or who recommend it tend not to follow the cases of women for two or three years after their surgery, and depression usually begins after the last post surgical checkup.[2] Surgeons do not see the relationship because they generally "sign off" on a patient after six months or one year, and depression generally emerges at the two to three year point.[3] More studies should be conducted between the third and fourth year to examine the relationship between the hysterectomy and depression. The author believes that there should be future studies to examine this relationship.

---

[1]Winnifred B. Cutler, Ph.D., *Hysterectomy Before & After*, (Harper Collins Publishers, 1990), 252.

[2]Ibid., 253.

[3]Ibid.

In conclusion, the variables were found to have a statistically significant relationship. Studies as early as 1968 revealed that hysterectomies seemed to be more closely associated with post operative depression than other forms of surgery.[4] Several studies were published throughout the 1970s and into the early 1980s, all showing similar phenomena.[5] More research and a larger sample size in this particular area will help to bring a better understanding of the relationship between hysterectomy and depression.

---

[4]Ibid., 254.

[5]Ibid.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The implication for social work practice is to assess clients from a humanistic approach in dealing with problems associated with hysterectomy. Since the role of the social workers is to improve the quality of life for people, they generally focus their efforts on assisting clients to cope more effectively with problems on living.[1] This additional knowledge about women's health and hysterectomy. Will enable women to make concious decisions concerning their health. I will support the social work profession in this role.

As a prospective social worker it is important to provide clients with step by step guidance through the maze of decisions and problems precipitated by the prospect of hysterectomy. Women must be more knowledgeable about hysterectomies, to make their own decisions about surgery.

Hysterectomies have been shown to increase the incidence of postoperative depression within three years of surgery particularly for women who had no uterine pathology. The reverse also has been documented. Women who had uterine pathology, such as fibroid tumors or very heavy bleeding, show an improvement in physical vigor within one to two years after surgery. This particular health issue is not simple. Hysterectomy may improve a woman's physical health, and she may feel better in spite of the organ loss. However, if nothing was wrong with the uterine tissue, the failure to solve the problem, coupled with the loss of an organ and its associated nerve and hormonal networks can cause severe physical and emotional problems. The concern is that these changes relate to depression which is known to be associated with suicide. Stressful life

---

[1]Christmas, 60.

events, such as: loss of job, a move to a new neighborhood, or a change in physical health can cause depression, and possibly lead to suicidal ideations. Depression can create emotional, cognitive, and social changes in people lives.[1] Knowing about the prevalence of depression, its impact, and the risk factors associated with it can increase the social worker's sensitivity to the problem and enhance his or her ability to identify people who are suffering from depression. This sensitivity is particularly important for social workers who work with individuals who initially seek help for other reasons, such as problems with elderly parents or financial difficulties caused by the loss of a job. Such clients may focus on the external aspects and realities of their difficulties, rather than on their feelings or functioning. Although they may benefit from some practical help, an assessment of the extent of their depressive symptoms will indicate whether these symptoms need to be directly addressed.

Secondly, an increased awareness of depression's impact and its risk factors can point to arenas for early detection and intervention. Although the risk correlated with major depression cannot be easily altered, knowledge of them can alert the social worker to high risk people and situations and suggest opportunities for early intervention. This may include populations of women who have undergone a hysterectomy.

---

[2]John H. Greist and James W. Jefferson, *Depression and Its Treatment*, (Washington, D.C.: American Psychiatric Press, Inc., 1992) , 37.

APPENDICES

APPENDIX A

To whom it may concern:

The office of Thermutus Mckenzie M.D., is willing to participate in the study conducted by MSW candidate Rosemary Moore. It is our understanding that the study will target women who have experienced a hysterectomy and may suffer from post-hysterectomy depression.

Our office will administer the questionnaire created by Ms. Moore, to our patients who have experienced the medical procedure

If you should have any questions regarding this matter, please feel free to contact this office.

Sincerely

Thermutus Mckenzie, M.D.

Dear Participant:

I am a graduate student at the Clark Atlanta University School of Social Work. As part of the research program , I'm required to complete a thesis as partial fulfillment for the degree of Master of Social Work. I am currently conducting a study of women who have experienced post- hysterectomy depression. In this study, I will investigate reasons why women experience depression as a result of having surgery. Demographic questions, questions pertaining to health, and depression will be included.

The information in this study is important to the profession of social work. It will enable social workers to provide clients with step by step guidance through the maze of decisions and problems precipitated by the prospect of a hysterectomy.

As a woman who has undergone a hysterectomy, you are invited to participate in this study. The questionnaire will take about 10 to 15 minutes to complete. Upon completion of the questionnaire, please return it to the receptionist or Ms. Debra Adams, the physician assistant. The data obtained from this study will be used to measure the level of depression experienced by clients who have undergone a hysterectomy. All of the information that you provide will be kept strictly confidential. Please do not write your name on this questionnaire so that your anonymity will be protected.

If you have any questions about this study, or if you are interested in the results, feel free to contact me. Your contribution to this study is greatly appreciated.

Sincerely,

Rosemary Moore

Rosemary Moore
Second Year MSW Student

cc : Dr. Gale M. Horton
Thesis Advisor
School of Social Work.

APPENDIX

QUESTIONNAIRE

Directions: The questions are broken down into categories, demographic information, questions pertaining to health and depression. Check the correct line which corresponds to your answer. Only one line should be checked for each question. Please answer all questions. There are no right or wrong answers.

SECTION I

1. Race:

1. White (not Hispanic) ___
2. Black/African American ___
3. Hispanic ___
4. Native American ___
5. Asian American ___
6. Other ___

2. Age:

1. 15 - 24 ___
2. 25 - 34 ___
3. 35 - 44 ___
4. 45 - 54 ___
5. 55 - 64 ___
6. 65 or more ___

3. Marital Status

1. Married ___
2. Single ___
3. Widowed ___
4. Divorced ___
5. Separated ___
6. Cohabiting ___

4. Educational Level:

1. High School ___ 2. College ___ 3. Graduate School ___
4. Other (specify) _____

5. Total Household Income:

1. Below $10,000 _____
2. $10,000 - $20,000 _____
3. $30,000 - $50,000 _____
4. Over $50,000 _____

SECTION II

Directions: This section refers to health. Please check the answer that best describes your health condition prior to your hysterectomy.

1. What age did you first start having symptoms that lead to a hysterectomy?

1. 15 - 24 ___
2. 25 - 34 ___
3. 35 - 44 ___
4. 45 - 54 ___
5. 55 - 64 ___
6. 65 or more ___

2. What Age did you have the hysterectomy?

1. 15 - 24 ___
2. 25 - 34 ___
3. 35 - 44 ___
4. 45 - 54 ___
5. 55 - 64 ___
6. 65 or more ___

3. What diagnosis led to your hysterectomy?

1. Fibroid tumor ____
2. Cervical cancer ____
3. Prolapse uterus ____
4. Endometriosis ____
5. Abnormal bleeding ____
6. Chronic menstrual pain ____
7. Other _____

4. Do you have a family history of hysterectomy? Yes ___ No ___

5. Were you given a choice of treatment? Yes ___ No ___

1. Myomectomy (remove the fibroids and leave the uterus intact) ___
2. Hysterectomy (remove the entire uterus) ___
3. Prescription drugs ___

6. Did you have any regrets of having surgery? Yes ___ No ___
7. Are you satisfied with you physical condition after surgery? Yes___ No___

SECTION III

Directions: This section refers to depression. Please check the appropriate line that best indicate your answer to the question.

1. Do your find yourself in a depressed mood sometimes? Yes ___ No ___
2. Do you have feelings of guilt about having a hysterectomy? Yes ___ No ___
3. Do you have thoughts about suicide? Yes ___ No ___
4. Do you have insomnia during the early morning hours? Yes ___ No ___
5. Do you work or have extracurricular activities? Yes ___ No ___
6. Do you become agitated sometimes? (Do things to yourself to bring about attention) Yes ___ No ___
7. Do you have feelings of anxiety? Yes ___ No ___
8. Do you have a lost of sexual interest? Yes ___ No ___
9. Did you have any menstrual disturbances prior to your surgery? Yes ___ No ___
10. Do you find yourself losing a significant amount of weight? Yes ___ No ___
11. Do you find yourself gaining a significant amount of weight? Yes ___ No ___
12. Do you have any paranoid symptoms? (Having delusions) Yes ___ No ___
13. Do you have obsessive compulsive symptoms? Yes ___ No ___
14. Do you have a slowness of thought or speech? Yes ___ No ___
15. Do you have an impaired ability to concentrate? Yes ___ No ___
16. Do you have decreased motor activity? Yes ___ No ___
17. Do you have a lose of interest in activities, hobbies? Yes ___ No ___
18. Did you seek medical advice or counseling for your condition? Yes ___ No ___

BIBLIOGRAPHY

Bernhard, Linda and Constance R. Harris. "Partner Communication About Hysterectomy." *Health Care for Women International*. (January-February 1997): 1.

Bradly, Gleen J. "Indications for Hysterectomy." *Med Seek, Modern Alternatives to Hysterectomy* (Book on-line): available from http://MedSeek.com/demo/modalt.htmi;Internet.

Breslin, Cathrin. "Is This Hysterectomy." *Women's Day Journal*. 57 (15 March 1994): 2-5. (Journal on-line), available from http://callisto.gsu.edu:4000/FETCH...=:reno=9:next-html/citation.html;Internet access 27 October 1997.

Christmas, Rachel Jackson. "Fibroids: A Report." *Essence*. (January 1994): 60.

Dr. Clark. "Menstrual Problems, Hysterectomy & Menopause." Clark Chiropractic Center, (Dr. Clark's Chiropractic on-line); available from http.//www.flash.net/clarkjm/menstrial.htm;Internet;accessed 28 October 1997.

Corey, Gerald. *Theory and Practice of Counseling and Psychotherapy,* 5th ed. California: Brooks & Cole Publishing Company, 1996.

Cutler, Winnifred B. *Hysterectomy Before & After*. Chicago, IL: Harper Collins Publishers, 1990.

Doctor's Guide. "Women Seek Alternative to Hysterectomy for Bleeding Problems." *Medical News*. (Doctor's Guide on-line); available from http://pslgroup.com/dg 1384a.htm; Internet; accessed 28 October 1997.

Dranov, Paula. "When the Diagnosis is Fibroids." *Journal of American Health.* (September 1993): 70.

Fetters, Michael D., Gayle Fisher, and Barbara D. Reed. "Effectiveness of Vaginal Papanicolaou Smear Screening After Total Hysterectomy for Benign Disease." *Journal of the American Medical Association* (March 1966): 940.

Greist, John H., and James W. Jefferson. *Depression and its Treatment*. Washington, DC.: American Psychiatric Press, Inc., 1992. 8.

Hamilton, M. Development of a Rating Scale for Primary Depressive Illness. *British Journal of Social and Clinical Psychology*. 6 (1967): 278-296.

_____. *Hamilton Rating Scale for Depression (HRSD)*. Glendale, California: Cinahl Information Systems, 1960.

Health Watch. Methodist Health Care System: Types of Hysterectomy. (Women's Health Resources on-line); available from http.//www.methodisthealth.com/WomensHealth/hysterec.htm; Internet; accessed 29 October 1997.

Healy, Bernadine. *A New Prespection for Women's Health.* New York: Penguin Books, 1995.

Kjerulff, Kristen H., Gay M. Guzinski, Patricia W. Langenbert, Paul D. Stolley, Nancy E. Adler Moye, Vahe A. Kazarddjiian. "Hysterectomy and Race." *Journal of Obstetrics and Gynecology.* 82 (November 1993): 759.

Knight, Kimberly. "Health Dairy Tales." *Essence* (May 1993): 60.

Kranner, Marcia G., Robert C. Reiter. "Hysterectomy: Indications, Alternatives and Predictors." *Journal of American Family Physician.* 55 (February 1997): 832.

Martin, Ronald L., William V. Roberts and Paula J. Clayton. "Psychiatric Status After Hysterectomy." *Journal of the American Medical Association* 244 (July 1980): 351.

Mayfield, E. "A Treatment For Fibroids." Health and Human Services Department, Division of Food and Drug Administration, (1993), 3, HE 20.4010: 27-9.

Morgan, Susanne. *Coping With A Hysterectomy.* New York: The Dail Press, 1989.

National Institutes of Health. "Conference Eyes Hysterectomy Alternatives." August 1994, (United States Health and Human Services Department, 1994): 3.

National Women Health Report, "Women's Health Resource Center on-line) available from http:www.Womenhealth.com/rch2.html;Internet; accessed October 1997, 1.

Newall, Linda. "How Hysterectomy Affects Women." M.S. diss, University of Loughborough, 1997.

Rosenthal, Sara M., and Suzanne Pratt. "*Everything You Need to Know About The Reproductive System and How It Works: The Gynecological Source Book.* Los Angeles: Jack Artenstein Publishers, 1994.

USA, Science. Study Launched on Hysterectomy Alternative (Women Health on-line), available from htt://www.usatoday.com/life/helath/women/hyster/iiwhyooi.htm; Internet; accessed 4 September 1997.

Villarosa, L. *Body & Soul: The Black Women's Guide to Physical Health and Emotional Well Being.* New York: Harper Collins Publishers, 1994.

Wallach, Edward E. "Myomectomy A Guide to Indications and Techniques." *Journal of Contemporary OB/GYN* (April 1988): 82.

Washington, Harriet A. "Fight Back Against Fibroids." Heart & Soul. (March 1994) : 32.

Webster's New Reference Dictionary of the English Language. (s.v. "Tennessee."), 1984.

Weil, M.D. Uterine Fibroids, Natural Health & Medicine: (Dr. Weil's Database on-line) available from http://egi.Pathfinder.comaawhxxpkg.UABs...il/database/display/014112,113,00.html;accessed 28 October 1997, 2.

West, Stanley. The Hysterectomy Hoax. New York: Doubleday Dell Publishing, 1994.

White, Evelyn C. "More on Fibroids." *Essence*. (December 1991): 26.

"The Fibroid Epidemic." *Essence*. (December 1991): 22.

Wilcox, L.S., L.M. Koonin, R. Pokras, L.T. Strauss, Z. Xia. "Hysterectomy in the United States." *Journal of Obstetric and Gynecology*. 83(4) (October 1990): 549-55, (Journal on-line); available from hhtp://earth4.galib.uga.edu:4000/f...=Freeno=3:next=htm/Citation.itation.html. Internet: accessed 28 October 1997.

Wiltz, Teresa. "Hysterectomy Hysteria." *Essence*. (October 1992): 24.